APPLICATION TO PARTICIPATE IN THE FAMILY PACT (PLANNING, ACCESS, CARE, AND TREATMENT) PROGRAM

(Section 24005, Welfare and Institutions Code)

IMPORTANT:

- Must be a current Medi-Cal provider.
- Read all attached materials before completing.
- Type or print clearly in ink.
- Signature of individual provider or individual is required (see page 4).
- *Return completed form to:*

  Department of Health Services
  Medi-Cal Provider Enrollment
  P.O. Box 942732
  Sacramento, CA 94234-7320
  (916) 323-1945

FOR STATE USE ONLY

Date received: _____

Date approved: _____

Date returned: _____

Date sent to OFP: _____

Enrollment Action Requested:

☐ New enrollment

☐ Additional site address—current Medi-Cal provider number: _____

☐ Request for continued enrollment—specify current provider number(s): _____

☐ Delete provider site (complete items 1–4 on page 1, page 2, if applicable, and page 4)

1.a. Legal name of applicant (must be same name as used for current Medi-Cal provider number)

1.b. Contact person for this application	1.c. Contact person's telephone number	1.d. Contact person's fax number
	( )	( )
2.a. Primary service site telephone number	**2.b. FAX number**	**2.c. E-mail address**
( )	( )	

3. Primary service site

4. Primary service site address (number, street)	City	County	State	Nine-digit ZIP code
5. Pay to address (number, street)	City	County	State	Nine-digit ZIP code
6. Mailing address (number, street)	City	County	State	Nine-digit ZIP code

7.a. Fictitious Business Name Statement number (attach copy), if applicable	7.b. Effective date	8. Date of birth	9. Gender
			☐ Male ☐ Female

10. Provider type (see Attachment A, Title 22 CCR, Section 51051)	10.a. Board-certified specialty	11. Current Medi-Cal provider number	12.a. License to Provide Health Services effective date (attach copy)	12.b. Expiration date

13. Federal Employer Identification Number (A copy of IRS Form 941, Form 8109–C, Form SS-4 [Confirmation Notification], or Form 2363 must be submitted with the application)	14. Social security number (If Sole Proprietor not using a Tax Identification number, you must disclose this number and attach a copy of the ITIN verification, if
___ ___ – ___ ___ ___ ___ ___ ___ ___	___ ___ ___ – ___ ___ – ___ ___ ___ ___ Name of Sole Proprietor (last, first, middle)

15. Clinical Laboratory Improvement Amendment (CLIA) number (attach copy)	State laboratory license/registration number	16. Driver's license number or state-issued identification number (attach legible copy)

17. List below all service sites, other than the one listed in question 4, at which Family PACT services will be provided. Identify the Medi-Cal provider number for each site. **List all provider numbers, service sites, and addresses that are applicable under this application.** Please attach a separate sheet of paper for any additional sites and Medi-Cal provider numbers not listed below.

Service site name	Medi-Cal provider number for this site			
Address (number, street)	City	State	ZIP code	Telephone number ( )
Service site name	Medi-Cal provider number for this site			
Address (number, street)	City	State	ZIP code	Telephone number ( )
Service site name	Medi-Cal provider number for this site			
Address (number, street)	City	State	ZIP code	Telephone number ( )
Service site name	Medi-Cal provider number for this site			
Address (number, street)	City	State	ZIP code	Telephone number ( )
Service site name	Medi-Cal provider number for this site			
Address (number, street)	City	State	ZIP code	Telephone number ( )
Service site name	Medi-Cal provider number for this site			
Address (number, street)	City	State	ZIP code	Telephone number ( )
Service site name	Medi-Cal provider number for this site			
Address (number, street)	City	State	ZIP code	Telephone number ( )
Service site name	Medi-Cal provider number for this site			
Address (number, street)	City	State	ZIP code	Telephone number ( )
Service site name	Medi-Cal provider number for this site			
Address (number, street)	City	State	ZIP code	Telephone number ( )

18. Practitioners

Please identify all practitioners (medical doctors, certified nurse midwives, nurse practitioners, physician assistants) who will be providing clinical family planning services under the Family PACT program. You may attach a list with the following information if it is easier than using the format provided below.

SERVICE SITE/ PRACTITIONER'S NAME	PROVIDER TYPE (e.g., M.D., CNM, NP, PA)	CALIFORNIA LICENSE NUMBER	MEDI-CAL RENDERING PROVIDER NUMBER (IF APPLICABLE)	IF NON-MD, PRESCRIBING AUTHORITY	
				Yes	No
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Orientation and Training Session

Applicants are required to attend a Provider Orientation session mandated by the legislation implementing Family PACT before they can participate in the Family PACT program. The yellow copy of the certificate of attendance must be attached to this Family PACT Application.

I have received, and have on file, a completed Practitioner Agreement from each practitioner identified in the Application. I am duly authorized to commit all service sites, provider numbers, and practitioners specified in this application. I understand that providers who do not provide services consistent with the "Family PACT Standards" for Administrative Practices and Clinical Reproductive Health Services may be permanently disenrolled as a provider from the Family PACT program. I understand that incorrect or inaccurate information may affect my eligibility to participate in the Family PACT program and receive Medi-Cal reimbursement and that I must report changes to the above information to the DHS Provider Enrollment Section. This includes any change of location or practitioner which must be reported to Medi-Cal Provider Enrollment within 35 days of the change. Failure to comply may result in permanent disenrollment from the Family PACT program.

Provider agrees: (a) that compliance with the provisions of this application is a condition precedent to payment to the provider. The parties agree that this application is a legal and binding document and is fully enforceable in a court of competent jurisdiction. The individual provider signing this application or the individual signing the application on behalf of a group understands it and is authorized to execute it; (b) to certify clients for eligibility for the Family PACT program, and recertify on an annual basis, according to certification instructions issued by DHS; (c) to cooperate with and participate in the evaluation effort of the Family PACT program determined by DHS; (d) to make administrative files and billing and medical records pertaining to the Family PACT program available at reasonable times for inspection, auditing, monitoring, or evaluation by state auditors/quality improvement staff for a period of four years from the end of the fiscal year in which the client encounter took place.

I declare under penalty of perjury under the laws of the State of California that the foregoing Application (DHS 4468), Provider Agreement (DHS 4469), Practitioner Agreement (DHS 4470), and Disclosure Statement (DHS 4471) information is true, accurate, and complete to the best of my knowledge and belief.

19. Type or print name of individual provider signing the application or individual signing the application on behalf of a group	Title of individual signing the application
20. Signature (original blue ink only)	Date

INSTRUCTIONS FOR COMPLETION OF APPLICATION TO PARTICIPATE IN THE FAMILY PACT PROGRAM

Delete as a rendering provider in a provider group means you no longer wish to be enrolled as a rendering provider in a provider group. Specify the provider group number.

1. Legal name means the name under which the applicant or provider is applying for enrollment or continued enrollment. Contact person who is familiar with the application and can be contacted for questions. Contact's telephone number and fax number.
2. Primary service site telephone means the primary business telephone number used at the business location. A beeper number, answering service, pager, facsimile machine, cellular phone, or answering machine is not acceptable. Also include fax number and e-mail address, if available.
3. Primary service site means, if the provider has multiple sites, the site considered the main or headquarters site.
4. Primary service site address means the actual business location including the street name and number, room or suite number or letter, city, county, state, and nine-digit ZIP code where Family PACT services are determined. A post office box or commercial box is not acceptable.
5. Pay to address means the address to which the applicant wishes to receive payment. The Pay to Address should include, as applicable, the post office box number, street number and name, room or suite number or letter, city, state, and nine-digit ZIP code.
6. Mailing address is where the applicant or provider wishes to receive general Family PACT correspondence. General Family PACT correspondence includes Medi-Cal Bulletin Updates and Family PACT Policies, Procedures, and Billing Instructions (P.P.B.I.) updates. Provide, as applicable, the post office box number, street number and name, room or suite number or letter, city, state, and nine-digit ZIP code.
7. If the name in number 2 is a Fictitious Business Name, provide the Fictitious Business Name Statement number. Attach a clearly legible recorded-stamped copy of the Fictitious Business Name Statement with the application. If nonapplicable, write "N/A." Provide the effective date of the Fictitious Business Name Statement or Fictitious Name Permit.
8. List the date of birth of the applicant if an individual owner.
9. List the gender of the applicant if an individual owner.
10. Indicate the provider type (see Attachment A list from Title 22, California Code of Regulations, Section 51051).
11. List current Medi-Cal provider number.
12. If individual provider or licensed community clinic, provide the license/certificate number, or other approval to provide health care, of the applicant or provider. Attach a clear legible copy of the license, certification, or approval. List the effective date and expiration date of the license/certificate number, or other approval listed in number 12. If a governmental agency, write "exempt."
13. List the Federal Employer Identification Number issued by the Internal Revenue Service (IRS) under the name of the applicant or provider. Attach a clearly legible copy of the IRS Form 941, Form 8109-C, Form SS-4 (confirmation notification), or Form 2363.
14. If the business is a sole proprietorship not using an Employer Identification Number, provide the social security number of the Sole Proprietor. List the Sole Proprietor's name. Provide a clearly legible copy of the social security card.
15. Insert the Clinical Laboratory Improvement Amendment (CLIA) number. Attach a clear legible copy of the CLIA certificate. Provide the state laboratory license/registration number. If this does not apply to you, enter "N/A."
16. Provide the driver's license or state-issued identification number and state of issuance of the applicant or provider. Attach a clearly legible copy with the application.
17. List all additional service sites at which Family PACT services will be provided.
18. List all practitioners and the service site where they will be providing Family PACT clinical family planning services.
19. Name and title of individual provider signing the application or individual signing on behalf of a group means the first, middle, and last name of individual who is applying to the Department for enrollment or continued enrollment as a provider in the Family PACT program (typed or printed).
20. An original signature, in blue ink, of the individual listed in number 19 is required. Also provide the title of the person signing the application. Include the city, state, and date where and when the application was signed.
21. Complete Attachment B, Identification Card Request Form, and include with mailed application. Failure to complete and mail this form with the application will severely delay receipt of HAP cards.

Remember to enclose a copy(ies) of the following, ***if applicable***:

- ⑨ Driver's license or identification card
- ⑨ Social security card
- ⑨ Tax identification number verification
- ⑨ CLIA certificate
- ⑨ License, certificate, or other approval
- ⑨ Fictitious Business Name Statement

⑨ Identification Card Request Form (Attachment B)

Title 22, California Code of Regulations
§ 51051. Provider.

(a) "Provider" means any individual, partnership, provider group association, corporation, institution, or entity, and the officers, director employees, or agents thereof, that provides services, goods, supplies, merchandise, directly or indirectly, to a Medi-Cal beneficiary, that meet the Standards for Participation specified in Article 3 (commencing with Section 51200), and that has been enrolled in the Medi-Cal program.

(b) Providers include, but are not limited to:

Acupuncturists
Assistive Device and Sick Room Supply Dealers
Audiologist
Blood Banks
Child Health and Disability Prevention Providers
Chiropractors
Christian Science Facilities
Christian Science Practitioners
Clinical Laboratories or Laboratories
Comprehensive Perinatal Providers
Dental School Clinics
Dentists
Dispensing Opticians
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Providers
EPSDT Supplemental Services Providers
Fabricating Optical Laboratory
Hearing Aid Dispensers
Home Health Agencies Hospices
Hospital Outpatient Departments
Hospitals
Incontinence Medical Supply Dealers
Intermediate Care Facilities
Intermediate Care Facilities for the Developmentally Disabled
Local Educational Agency Providers
Nurse Anesthetists
Nurse Midwives
Nurse Practitioners
Nurse Facilities
Occupational Therapists
Ocularists Optometrists
Orthotists
Organized Outpatient Clinics
Outpatient Heroin Detoxification Providers
Personal Care Service Providers
Pharmacies/Pharmacists
Physical Therapists
Physicians
Podiatrists
Portable X-ray Services
Prosthetists
Providers of Medical Transportation
Psychologists Rehabilitation
Centers Renal Dialysis Centers and Community Hemodialysis Units
Respiratory Care Practitioners
Rural Health Clinics
Short-Doyle Medi-Cal Providers
Skilled Nursing Facilities
Speech Therapists
Targeted Case Management Providers

Barclays CA, pages 403 and 404. Register 99, No.40; 10-1-99. DHS 4468 Application Attachment.

FAMILY PACT PROGRAM

HEALTH ACCESS PROGRAMS (HAP)
IDENTIFICATION CARD REQUEST FORM

Under the Family PACT (Planning, Access, Care and Treatment) Program, client eligibility will be determined by the medical provider based upon the information provided by the client under self-certification. The provider will issue a **Health Access Program** (HAP) identification card to the client. The client will use this card for access to other medical providers as well as pharmacies and laboratories.

To provide the HAP cards to your clients, it will be necessary to estimate the number of new Family PACT clients you will see during the next six month period. HAP cards will be mailed to the primary provider number indicated on the *Application and Agreement*. All other individual sites listed on the *Application and Agreement* must order their own cards after the application has been approved. Sites are not allowed to share cards.

This form is for a one-time only order for the first quantity of cards you estimate you will need. For a first time INITIAL ORDER ONLY, please complete the information below and return this form with your *Application and Agreement.* HAP enrollment cards will be issued in blocks of 100. For this initial order, please ONLY order the quantity expected to be used for a six-month period.

Provider name

Street address

City	State	Zip

Provider number	Provider telephone number
	( )

Number of Health Access Program (HAP) identification cards needed:_____
(Order a six-month supply in blocks of 100.)

Please allow two weeks for receipt of your order.

FOR ALL FUTURE ORDERS, CALL THE HEALTH ACCESS PROGRAMS HOTLINE AT 1-800- 257-6900

June 2001